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REVIEW OF FURTHER DEVELOPMENTS IN FIELDS WITH WHICH THE SUBCOMMISSION HAS BEEN CONCERNED

Preliminary report of the Special Rapporteur on traditional practices affecting the health of women and children, Mrs. Halima Embarek Warzazi

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Introduction

1. At its forty-sixth session, on 26 August 1994, the Subcommission adopted resolution 1994/30 entitled "Traditional practices affecting the health of women and children", in which it decided to recommend that the Commission on Human Rights extend the mandate of the Special Rapporteur, Mrs. Halima Embarek Warzazi, for two more years, in order to enable her to undertake an in-depth study to assess, inter alia, the differences and the similarities between traditional practices affecting the health of women and children in many parts of the world, taking into consideration, among other relevant documents and information, the conclusions and recommendations of the two regional seminars and the effects of the implementation of the Plan of Action.

2. The Subcommission, in the same resolution, requested the Special Rapporteur to submit her preliminary report at the forty-seventh session and her final report at the forty-eighth session of the Subcommission.

3. At its fiftieth session, on 3 March 1995, the Commission on Human Rights, by its decision 1995/112, endorsed the recommendations of the Subcommission.

4. On 28 April 1995, the Secretary-General sent a note verbale to Governments transmitting a request for any relevant documents and information, in particular on the effects of the implementation of the Plan of Action for the Elimination of Harmful Traditional Practices affecting the Health of Women and Children, to assist the Special Rapporteur in her work.

5. Such a request for information was also addressed to specialized agencies, United Nations bodies and organs, as well as intergovernmental and non-governmental organizations.

6. At the time of submission of the present report replies had been received from Armenia, the Czech Republic, Germany, Kiribati, Spain, Ukraine and Uruguay, as well as from the Economic and Social Commission for Asia and the Pacific, the Economic Commission for Latin America and the Caribbean, the Office of the United Nations High Commissioner for Refugees, the United Nations Children's Fund, the United Nations Educational, Scientific and Cultural Organization and the United Nations Population Fund.

7. Information was also received from the Inter-American Commission of Women of the Organization of American States and the International Federation of Red Cross and Red Crescent Societies, as well as the following non-governmental organizations: Arab Council for Childhood and Development, Asian Mass Communication Research and Information Centre, Commonwealth Medical Association, Inter-African Committee on Traditional Practices Affecting the Health of Women and Children, International Council of Nurses, International Federation of Human Rights, International Federation - Terre des Hommes and Victim Support.

8. In this preliminary report the Special Rapporteur intends to address, in accordance with Subcommission resolution 1994/30, the similarities and differences between traditional practices affecting the health of women and children in many parts of the world on the basis of the two regional seminars held on the subject in Africa and Asia, respectively.

9. The Centre for Human Rights, in cooperation with the Government of Burkina Faso, organized the first United Nations Regional Seminar on Traditional Practices Affecting the Health of Women and Children at Ouagadougou, from 29 April to 3 May 1991, the report of which is contained in document E/CN.4/Sub.2/1991/48. The second United Nations Regional Seminar on Traditional Practices was organized by the Centre for Human Rights, in cooperation with the Government of Sri Lanka, at Colombo, from 4 to 8 July 1994. The report of the seminar is contained in document E/CN.4/Sub.2/1994/10 and Corr.1.

10. On the basis of the deliberations of the two regional seminars, the Special Rapporteur submitted a Plan of Action for the Elimination of Harmful Traditional Practices affecting the Health of Women and Children for the consideration of the Subcommission at its forty-sixth session, with a view to providing action-oriented and concrete proposals and positive changes to redress the situation at national and international levels.

11. The Special Rapporteur will consequently, in her final report, examine in depth the progress achieved and the difficulties encountered in the implementation of the Plan of Action for the Elimination of Harmful Traditional Practices affecting the Health of Women and Children, as contained in document E/CN.4/Sub.2/1994/10/Add.1 and Corr.1. In this connection, a detailed analysis of the replies received will be made and final recommendations will be offered.

12. An analysis of differences and similarities in traditional practices affecting the health of women and children at global level will permit the Special Rapporteur to determine which types of effective intervention mechanism are needed in the different regions. This analysis can, therefore, be directly linked to the progress achieved and the difficulties found in implementing the Plan of Action.

I. TRADITIONAL PRACTICES

13. The peoples of the world are distinguishable not only by their nationality, religion, civilization and language, but also by their mentality. This mentality, forged by usages, customs and humanitarian and social spiritual values, represents the profound expression of the way of life of peoples as a whole, of a particular people among other peoples or of a group within a particular people.

14. As is well known, long before the concept of a nation and membership of that nation took firm root, human relations were centred on a group, a tribe, a clan, a family and a geographical area where traditions and customs, passed down from generation to generation, were respected and even jealously guarded.

15. One of the areas which has given rise to the greatest misunderstanding, contempt and intransigence, leading in most cases to incompatibilities and tensions in relations between peoples, groups and individuals, is that of culture, religion, customs and traditions.

16. Under the impulse of progress and modernity, with their full complement of mobilization, differentiation and secularization, traditions and practices have fallen into disuse in western societies, which are now characterized by industrialization, economic and social development and unprecedented changes in attitudes and behaviour leading to emancipation, more pronounced individualism, the break-up of the family, and the relaxation - not to say decline - of moral standards.

17. On the other hand, poverty and ignorance, the sway of religion and beliefs, respect for family structures and social constraints and - a factor which should not be overlooked - colonialism have, in the third-world countries, helped to keep alive traditions which in some cases go back thousands of years and to perpetuate practices in which traditional societies engage with conviction and fidelity because they have always formed part of their everyday lives.

18. It is true that since the most remote times it is men who have forged the practices which have characterized or continue to characterize the peoples of the world, but there seems to be no doubt that women, who have been the victims of many of these practices, are often the ones who have perpetuated them in traditional societies.

19. Those traditional practices which should now be abolished are those which jeopardize the health, well-being and dignity of women. There is no doubt that among traditional practices some must be maintained and encouraged. But today, many practices are particularly harmful for women and children because they endanger their physical and mental health and jeopardize their future and dignity. Some of these practices have been identified through the two above-mentioned seminars.

II. DIFFERENCES IN TRADITIONAL PRACTICES

A. Female genital mutilation

20. On the basis of the outcome of the two regional seminars, it appears that the major difference observed in connection with traditional practices in Africa and Asia is the expression or the type of the practice itself. For example, it is noted that the agenda of the African regional seminar provided for detailed discussion of female genital mutilation, son preference and traditional birth practices presenting risks to safe motherhood, whereas, at the Asian regional seminar, son preference and traditional practices related to marriage were priority concerns.

21. Female genital mutilation, a practice which involves the cutting away of all or part of the external female genital organs is prevalent mainly on the African continent. According to the World Health Organization, the number of sexually mutilated women and girls in Africa, and in some parts of Asia, had increased to between 85 and 115 million in 1994, and a further 2 million girls are estimated to be at risk of the practice each year. In addition, it should be mentioned that immigrant communities living in Europe, Australia, Canada and the United States of America also might practice some forms of female genital mutilation.

22. Although the practice is prevalent in 26 African countries, the types of female genital mutilation vary considerably across the continent. Infibulation, which is the most extreme form of female genital mutilation and which causes the most damage to girls' and women's health in the immediate and long term, is practised predominantly in Djibouti, Somalia, the Sudan, some parts of Egypt and Ethiopia, whereas excision, involving the removal of the clitoris and the labia minora, and circumcision, the removal of the clitoris, constitute approximately 85 per cent of the practice in West, Central and East Africa. The sexual mutilation of women is also found in some parts of Asia, such as Indonesia, Malaysia and Yemen. Contrary to the African practice, however, in Asia there exist communities where the ritual is performed in a purely symbolic manner by placing a knife on the clitoris of the woman without actually using it or by marking the clitoris lightly with a reed.

23. Differences may also be detected in the average age of the girls on whom the practice is carried out. In West Africa, were female genital mutilation is seen as a "rite of passage" from childhood to womanhood, the age at which the practice is performed tends to be around 14 or 15, when the young woman becomes fertile. In this connection, it is also common for elaborate rituals to be performed during the act. In East Africa, female genital mutilation is traditionally practised in order to control sexual desire and to preserve virginity, and frequently girls have to undergo the procedure at the age of 7 or 8. According to the World Health Organization, it appears that the average age is generally falling, indicating that female genital mutilation is having less and less to do with initiation into adulthood. In addition, it is stipulated that the differences in age according to the area are also linked to whether legislation prohibiting the practice is in force.

B. Son preference

24. In contrast to female genital mutilation, which was only considered at the African regional seminar, the practice of son preference was treated in detail at both regional meetings. The Working Group on Traditional Practices affecting the Health of Women and Children, which was established in 1985 and which submitted its report to the Commission on Human Rights at its forty-second session in 1986, defined son preference as the preference of parents for male children, which often manifested itself in neglect, deprivation or discriminatory treatment of girls to the detriment of their physical and mental health (E/CN.4/1986/42, para. 143). Son preference was generally recognized to exist in most countries in Africa and Asia - perhaps to a more marked extent in the latter - as a transcultural phenomenon which varied in intensity and expression from one country to another.

25. South Asia (Bangladesh, India, Nepal and Pakistan), as well as Western Asia (Jordan, Syrian Arab Republic) and some parts of Africa (Algeria, Cameroon, Egypt, Liberia, Libyan Arab Jamahiriya, Senegal, Tunisia) were identified by the Working Group as most affected (para. 151). Son preference is also prevalent in Morocco but the Government has for the past two years given great importance to "the little girl" through policies and activities aimed at combating this tradition.

26. At both seminars, the historical roots of the phenomenon were attributed to the existence of patriarchal systems. Furthermore, participants at both seminars felt that economic considerations, such as the traditional role of men in agriculture and as property owners, underlay this type of discrimination against women. Whereas, in Africa it was recognized that religion or erroneous interpretation of the religion might also be one of the causes of the practice (because, for example, women were not allowed to perform certain religious functions and ceremonies), it is interesting to note that in Asia it was clearly stated that the practice was not based on religion. Buddhism, promoting egalitarian societies resulting in non-discriminatory social policies providing for free food, education and health care, was cited as an example in that regard.

27. While the phenomenon of son preference was a traditional practice affecting the health of women and girl children throughout their entire life cycle, it was found that practices such as female foeticide or infanticide were more prevalent in Asian than in African societies, where son preference more frequently expressed itself in the form of nutritional and educational differences between the sexes. In addition, it was found that in both Asian and African countries women's access to employment and economic opportunities was severely hampered due to discrimination.

C. Traditional marriage and related practices

28. The issue of traditional marriage and related practices was considered much more extensively at the Asian regional seminar. It was stressed that in the Asian region both marriage and motherhood were mandatory. Women were generally required to marry at a young age and were frequently subjected to virginity tests and virginity control. Early marriage and resulting early maternity adversely affected the health, nutrition, education and employment opportunities of women and lowered their life expectancy. As a result, maternal and child mortality rates were extremely high in the region, with South Asia recording the highest maternal mortality rate of 650 maternal deaths per 100,000 births. At the seminar, it was stated that marriage and procreation were affected by religious, social and economic factors such as unequal access to education and training; however, economic security for women was cited as one of the main reasons why the practices were condoned.

29. In the African region, it was felt that son preference, widespread in this continent, also frequently led to early marriages. Although in Africa harmful traditional marriage practices were not as prevalent as in Asia, in some countries, notably in East Africa and in Nigeria, the number of girls married at an early age was increasing, as young virgins were less likely to be infected with HIV/AIDS and, therefore, were seen as fit and healthy brides.

30. Practices related to early marriage and pregnancy which were detrimental to women's well-being were acknowledged to exist, in particular in South Asia, for example in the form of dowry payments to compensate for the low status of the woman. Such practices might take particularly violent forms, including torture and abuse perpetrated by the family, sometimes resulting in so-called dowry deaths and bride burnings. It should also be mentioned that the younger the bride the lower the dowry, another encouragement to early marriages.

31. Another difference in marriage-related practices was the fact that in Asia, young brides were frequently under the control of their mother-in-law resulting in confrontations, maltreatment and oppression by the mother-in-law and the wider family, whereas in Africa the young bride was more likely to be subjected to ill-treatment by her husband and the immediate family. The manifestation of the practice might differ, but the consequences for the woman remained the same.

D. Traditional birth practices

32. At the African regional seminar, the issue of traditional birth practices presenting risks to safe motherhood was identified as one which prevailed across the whole region. This was attributed not only to cultural values but also to the difficulty in obtaining adequate health care, education and information with regard to childbirth. Delivery practices harmful to the health of women were frequently linked to births assisted by traditional midwives and to the acute lack of hygienic and safe conditions. In addition, in some countries in Africa, such as Ghana, nutritional taboos during pregnancy weakened women, leading to complications at delivery.

33. In Asia, childbirth assisted by traditional untrained birth attendants was also recognized as being widely practised. However, certain traditional practices related to delivery were identified as beneficial to the mother and child. Breast-feeding and "rooming in" were cited as positive examples.

III. SIMILARITIES IN TRADITIONAL PRACTICES

34. From the above accounts, it is clear that whatever the practice may be, and wherever it exists, the origins lie in the historically unequal economic and social relationships between men and women, resulting in a perceived inferior status of the woman. It is, therefore, not surprising that the consequences of these age-old practices have the same devastating effects on girls and women throughout the world, regardless of the expression the traditional practice may take and whether it occurs in Asia, Africa or elsewhere.

A. Causes

35. Participants at both regional seminars agreed on the global prevalence of certain historical, cultural, social and economic factors which perpetuated traditional practices harmful to the health of women and children. The unequal power relations between men and women, promoting male supremacy and the subordination and vulnerability of women, were firmly integrated into the traditional value systems of societies where such practices continued to exist.

36. In connection with female genital mutilation, the reproductive role of women in traditional societies was frequently mentioned. It was felt that the lower status of women was perpetuated by a desire to control female sexuality, for example by removing women's sensitive sexual organs so as to quell their sexual desire, to preserve their virginity or to ensure purity of lineage. In

addition, pressure by the community towards conformity and social acceptance often drove young girls and their mothers to subject themselves to such practices, which allowed them to be accepted by the community as full members.

37. Similar reasons were put forward regarding the practice of early marriage, even child marriage. Early marriage was perceived as a guarantee for a long cycle of fertility, firmly entrenching women in their most important role as mothers. In addition, the economic benefits of a girl whose virginity was guaranteed, whether through genital mutilation or early marriage, were recognized as causes for these practices, since a virgin girl was considered a financial asset in terms of dowry.

38. In the same vein, it was stated that son preference and the low status accorded to girls and women were two sides of the same coin, as the preference for one sex over another had led to the conscious or unconscious neglect of daughters, resulting in their low and, often, negative self-esteem and loss of dignity. As mentioned earlier, it was emphasized at both regional meetings that son preference was stronger in countries where patriarchy was firmly rooted. It has been noted, however, that in certain regions where women are needed for agricultural purposes son preference is not prevalent.

39. Furthermore, in both the African and Asian regions, it was argued that the practice of son preference had emerged with the shift from subsistence agriculture, primarily controlled by women, to settled agriculture, primarily controlled by men. This in turn reinforced the role of men as providers and caretakers, as work force and as property owners, so that the only guarantee of security for a woman would be through a man: her father, her brother, and eventually her husband and her sons. At the Asian regional meeting, the prevalence of son preference was also closely linked to situations of scarcity and poverty where limited resources had to be invested optimally, to the detriment of the girl child.

40. The question of religion as a cause of harmful traditional practices is a very sensitive one. It is, however, possible that in cases where certain traditional practices are perceived to be required by religion, the misinterpretation and misuse of religion may create social mechanisms to control the status of women, resulting in the denial of their identity and integrity. In a vicious circle, the perceived low status of women within their communities has excluded them from, for example, influencing religious interpretations which may reinforce their inferiority and vulnerability.

41. As a result of long-standing perceptions of traditional roles for men and women, many of the practices described above which severely affect the health of women and children have evolved to become accepted norms of social behaviour. In many cases, in Africa and Asia alike, this socialization process has reached such an extent that women themselves emerge as guardians of the practices because no alternatives are available.

42. At both regional seminars it was repeatedly emphasized that one of the major causes for the continuing existence of such traditional practices was the lack of information and access to education. A direct correlation in this regard has been established by WHO, which noted that incidences of female genital mutilation have decreased in urban areas, among communities with

higher literacy rates. Consequently, if women indeed appear to be guardians of the practices, it is because they cannot act on the basis of an informed choice but are surrounded by myths, misperceptions and discriminatory practices and traditions created by men.

B. Consequences

43. Similarities may be detected at a global level, not only in the deep-rooted causes perpetuating traditional practices but also in their harmful consequences. It should also be noted that these consequences do not only, as the title suggests, affect the health of women and children but their social and economic status and living conditions as well, so that the effective enjoyment of their human rights is seriously impaired.

44. The physiological and psychological health of girls and women subjected to harmful traditional practices are commonly impaired in Africa as well as in Asia, whether such practices take the most extreme form of genital mutilation or the more disguised form of neglect and discrimination as a result of son preference.

45. At the African regional seminar, the health consequences of female genital mutilation were discussed in detail. It was said that physical damage often due to the use of unhygienic methods and instruments, included vaginal haemorrhage and numerous genito-urinary and obstetric complications, tetanus, blood poisoning, as well as, increasingly, HIV/AIDS infection. In addition, female genital mutilation usually rendered sexual intercourse very painful and difficult for women, often resulting in frigidity. Furthermore, the shock triggered by the procedures, often performed without any anaesthesia, had long-lasting psychological effects on the girls. Similar severe consequences could be observed in regions where early marriage and early pregnancies existed. As already mentioned, in those cases life expectancy lessened considerably and maternal and child mortality rates were extremely high, South Asia being a point in case.

46. Closely linked was the societal pressure for a son; young women and girls were pushed into unwanted and recurrent pregnancies in the hope of a baby boy. Additionally, as child brides themselves were frequently victims of the effects of son preference, they often suffered from poor nutrition and might not have finished growing themselves, leading to nutritional deficiencies in both mother and baby. The delivery practices mentioned above could also have similar consequences for the well-being of girls and women. Certain nutritional taboos to which pregnant women were subjected weakened them so that complications arose during childbirth.

47. The discriminatory practices carried out as a result of son preference were also highlighted at both seminars and appeared to be equally prevalent in Africa and in Asia. Along with female foeticide, often illegal and sometimes self-induced and female infanticide, girl children were often deprived of food to the benefit of their brothers; feeding a daughter was often perceived as "watering the neighbour's garden", i.e. simply not a beneficial investment. In Asia, sex discrimination in feeding had been noted to lead to a higher incidence of malnourishment and mortality rates among female children. At the

African seminar it was noted that discriminatory practices favouring the male child also included the denial of health care to girl children, particularly in Asia and in North Africa, thereby increasing their mortality rate.

48. Similarities in negative affects of traditional practices on women are not only related to health, but also to education. Families living on limited resources tend to give priority to the education of the males. In fact, at the Asian seminar it was stated that gender discrimination and its negative effects had generally declined in countries whose Governments had provided free education and free health services to both women and men. It should be mentioned in this context that educational institutions may sometimes reinforce the stereotyping of women in their traditional roles. In general, however, it was stated that in the Asian region, the advancement of the status of the women and the welfare of the child in the family and society were symbiotically linked with socio-economic development of the nation.

49. The most common factor in all the various types of traditional practice is the violent form they take. It is increasingly argued, for example in the report of the Special Rapporteur on violence against women (E/CN.4/1986/42), that violence against women plays a major role in human history, manifesting itself in various forms and social practices. Women are so routinely subjected to violence in the family and in the community that this long-standing reality is accepted as a part of tradition and culture.

50. From the above accounts of the negative consequences that certain traditional practices have on women and children, it may be argued that traditional practices such as son preference, female genital mutilation, early childhood marriage and related practices constitute manifestations of violence against women. In this connection, the Declaration on the Elimination of Violence against Women, adopted by the General Assembly in its resolution 48/104, expressly states in its article 2:

> "Violence against women shall be understood to encompass, but not be limited to, the following:
>
> (a) Physical, sexual and psychological violence occurring in the family, including ... dowry-related violence ... female genital mutilation and other traditional practices harmful to women ..."

51. At the Asian regional seminar, it was further argued that the subordinated status of women was closely linked to the perpetuation of such practices, and even encouraged violent attitudes. Violence against women was one of the crucial mechanisms by which women were forced into a subordinate position to men.

52. It was also recognized that in both the Asian and African regions legislative measures aiming at the elimination of harmful traditional practices were lacking. Where such legislative provisions existed, their implementation was less than effective. It was also noted that the issue of harmful traditional practices had only been brought to the forefront through the activities of non-governmental organizations such as the Inter-African Committee on Traditional Practices affecting the Health of Women and Children which had national affiliates in many African countries. The community of

non-governmental organizations in Africa appeared to be much more organized with regard to the elimination of traditional practices than its Asian counterpart. It seemed that the "critical mass" at which Governments were sensitized to the issue had not yet been reached.

IV. PRELIMINARY CONCLUSIONS

53. The objective of the two regional seminars in Africa and in Asia was to assess the human rights implications of certain traditional practices affecting the health of women and children. During the discussions it was observed that despite the seriousness of the problems involved and the numerous resolutions and recommendations adopted at the international, regional and national levels, the question of traditional practices affecting the health of women and children had not received the attention it deserved from most of the States concerned. Furthermore, in the view of the participants in the seminars, such practices persisted because of a lack of political will on the part of many States and the failure to inform and educate both women and men.

54. Judging from the differences and similarities in traditional practices that were identified on the basis of the discussions at the regional seminars, it can be concluded that despite the different manifestations of harmful traditional practices depending on the region and the country, the root causes and the negative consequences for the women and girls remain essentially the same. It is for these reasons that the Special Rapporteur is convinced that the Plan of Action for the Elimination of Harmful Traditional Practices affecting the Health of Women and Children, as elaborated on the basis of the two seminars and as adopted by the Subcommission at its forty-sixth session, provides a global framework for action at the national, regional and international levels.

55. The Special Rapporteur, therefore, calls upon all States, United Nations bodies and organs, relevant specialized agencies, as well as non-governmental organizations and grass-roots movements to implement the Plan of Action and to report to her on the progress achieved and the obstacles encountered in doing so. In her final report the Special Rapporteur intends to analyse closely the replies received in this connection, so as to make recommendations on improved action for the elimination and eradication of harmful traditional practices affecting women and children.